Keith Papendick, M.D.
08/23/2021

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

ANDREW LYLES,
#667516,
Plaintiff,

vs.

PAPENDICK et al,
Defendant.
_____/

Case No. 2:19-cv-10673
District Judge: Laurie J. Michelson
Magistrate Judge: Patricia T. Morris

VIRTUAL ZOOM DEPOSITION OF KEITH PAPENDICK, M.D.

taken remotely via Hanson Renaissance Court Reporters & Video, commencing on Monday, August 23, 2021, at 11:02 a.m.

APPEARANCES:

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REPORTED BY: Ms. Diane Murray, CSR-4019, RPR

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EXHIBITS
(Attached hereto.)

Monday, August 23, 2021 - 11:02 a.m.

COURT REPORTER: We're now on the record. I am not in the same location as the witness and this deposition is being conducted remotely.

Hearing that there are no objections to administering the oath remotely, I will now swear in the witness.

KEITH PAPENDICK, M.D.,
having been called and duly sworn:

EXAMINATION

BY MR. CROSS:

Q. Morning, Dr. Papendick. Nice to see you again. My name's Ian Cross. I represent the Plaintiff, Andrew Lyles.

Something I want to go over first, because we had some trouble with it last time, when I ask you a question, I need you to answer the question that I asked you and not another question.

Do you understand what that means?

A. Yes.

Q. What does it mean?

A. That means that I answer the question you have and not try to get any more information in.

Q. Okay. Did you review any documents in preparation for today's deposition?

A. Just the medical record.

Q. What medical records did you review?

A. I believe they were supplied by you and the 407's that I had done.

Q. So you reviewed your 407's and you reviewed some medical records?

A. 407 is a medical record.

Q. Did you review a transcript of a deposition?

A. No.

Q. Okay. Did you review any UpToDate literature?

A. No.

Q. All right. Are you a medical doctor?

A. I am.

Q. Did you have to complete some education or training to become a medical doctor?

A. I did.

Q. What education or training did you complete?

A. I have my medical doctor's degree from Wayne State University, School of Medicine, in Detroit.

Q. Were you taught about the human digestive system in medical school?

A. Of course.

Q. Can you please identify each of the components of the human gastrointestinal tract, starting with the mouth and ending with the anus, and for each component give us a brief description of the function it performs?

MR. SCARBER: Just going to object to form -- Dr. Papendick -- and the foundation -- Dr. Papendick isn't your expert witness here. I mean if you've got a question you want to ask him specific about Mr. Lyles and his decisionmaking with respect to that, that's fine, but my objection is to form and foundation, and you also asked about four questions in one question.

So I'm not going to stop your question but that's my objection. You might have to break it down.

BY MR. CROSS:

Q. You may answer.

MR. SCARBER: If you understand his question, go ahead.

A. Well, it's an extensive question. You have the lips, the teeth, the mouth, which is, will break the food into smaller pieces, mixing it with amylase. You have the oral pharynx where the food goes into the esophagus. You have the esophagus, which functions to move the food from the oral pharynx into the stomach. You have the stomach, which digests the food, it's highly acid, and it's not total digestion but it's the breakdown of the macromolecules into smaller sections. The duodenum, which is the first part of the small intestine after the stomach, and in the duodenum, you mix with the pancreatic juices, which include amylase, lipase and protease, which

breaks down starch, lipase, fat and protein into its basic molecules of the food which are then absorbed through the small intestine. At the point of the small intestine going into the large intestine is the ileocecal valve and, after it goes through there, the function is predominantly to absorb water. So when the contents of the bowel go into the large intestine, it's all liquid and when it comes out, of course, it's not supposed to be liquid.

Q. Okay. You mentioned that the process of digestion involves acid; correct?

A. Correct.

Q. Where in the digestive tract is the acid located?

A. In the stomach.

Q. Is there acid in the large intestine?

A. Typically it's right at neutral.

Q. Okay. What is a proton pump inhibitor?

MR. SCARBER: Let me just place an objection to foundation as well. Some of these questions are fairly general and can be different with respect to different patients, but go ahead. Next question.

THE WITNESS: I didn't hear him.

MR. SCARBER: Okay.

BY MR. CROSS:

Q. Did you hear my question?

A. No.

Q. Okay. What is a proton pump inhibitor?

A. It is a medication and chemical that stops the stomach from making acid.

Q. Okay.

A. Well, it decreases the stomach from making acid.

Q. What do you do for a living?

A. I'm a physician.

Q. By whom are you employed?

A. Quality Corrections -- Quality Corrections Care of Michigan, P.C.

Q. What is your job title?

A. Utilization management medical director.

Q. How long have you been a utilization management medical director?

A. Since 2014.

Q. What did you do before you were a utilization management medical director?

A. I was a hospitalist at Duane Waters Health Center in Jackson.

Q. What is Duane Waters Health Center?

A. It is the prison's -- it used to be a hospital. It's now just a health center.

Q. What is utilization management?

COURT REPORTER: You're echoing really bad, Ian.

MR. CROSS: I don't know what to do about that.

COURT REPORTER: We can keep trying and see how it goes, I guess.

BY MR. CROSS:

Q. What is utilization --

A. Utilization management is --

MR. SCARBER: You want him to answer?

MR. CROSS: If he heard the question.

MR. SCARBER: You were just talking over each other. I apologize, but there is a slight, a slight delay. He's gonna answer your question about what utilization management is. Go ahead.

A. Utilization management is the department that reviews requests for off-site visits and looks at, in our medical judgment, looks at whether they are best for the patient.

BY MR. CROSS:

Q. What is the purpose of utilization management?

COURT REPORTER: Excuse me. There's delays and echos.

(At 11:15 to 11:23 a.m., recess taken to troubleshoot Zoom connection.)

(At 11:23 a.m., record repeated by reporter as follows: "Q. What is the purpose of utilization management?")

A. I answered that question.

BY MR. CROSS:

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Q. Well, then we didn't hear it.
A. Oh, great. Utilization management is the department that looks at the requests to make certain that the patient is getting the best care.
Q. So the purpose of utilization management is for the benefit of the patient?
A. Absolutely.
Q. And how does it benefit the patient, to review requests for off-site services?
A. Because sometimes off-site services are not, in medical judgment, the best thing for the patient and, thus, we tell them that.
Q. So do you have any information to judge the propriety of an off-site service that the doctor on site doesn't have?
A. No. Just purely medical judgment.
Q. Are you board certified in any specialty?
A. Not any longer.
Q. Were you previously board certified in any specialty?
A. Yes, I was.
Q. What was that specialty?
A. Family practice.
Q. What is the difference between family practice and internal medicine?
A. Family practice takes care of pediatric patients and sometimes OB as well as internal medicine.

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Q. And what does internal medicine do?
A. They look at the medical care of the patient without doing pediatrics or OB.
Q. Okay. What are your job duties as a utilization management medical director?
A. Review 407's.
Q. What's a 407?
A. 407 is a document that is called a 407 because that's what it was when it was on paper at the Michigan Department of Corrections, and so they continued to use the nomenclature. It's a consult request.
Q. Can you describe the process of how the request gets to you?
A. The request is placed in the computer, it then goes to my nurse who puts it into CARES, and I review the case from there.
Q. So what's CARES?
A. CARES is a program developed by Corizon Health for the utilization management to look at reviews and/or those reviews to be sent to billing so that the bill can be paid.
Q. Does utilization management have anything at all to do with cost control?
A. No.
Q. When you received the 407 request in CARES, do any

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documents come along with that 407 request, such as medical records?
A. A 407 is to be all-inclusive of everything I need but, on occasion, I have asked for more records.
Q. Okay. This CARES process, was it in place in 2016?
A. It was coming into -- it came into fruition in 2016.
Q. Do you know when, in 2016, it came into fruition?
A. No.
Q. So in, for example, November of 2016, you don't know if you would have be using CARES or not?
A. Absolutely not certain.
Q. Okay. And you testified that all of the information you need to make a decision must be contained in the request; correct?
A. The providers are told that all of the information is to be in the 407.
Q. Is there a section in the 407 called Failed Outpatient Therapies?
A. I don't believe so. I don't know.
Q. So Failed Outpatient Therapies are not listed in the 407?
MR. SCARBER: Just going to place an objection. If you have a form that you want to refer to him or put up, so you can show him the 407 in which you're talking about, I think that would be better.
BY MR. CROSS:

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Q. Go ahead.
A. I don't look at the 407.
Q. You don't?
A. No. The 407's are put into CARES.
Q. So what do you look at if not the 407?
A. The CARES entry.
Q. Okay. Why do doctors at the prisons need to get your approval for certain procedures?
A. They need to get my approval because I have had some training that allows me to look at what's best for the patient and not necessarily what they want.
Q. What was that training?
A. I have twenty-five years of medical practice in managed care and then what I received when I first came on the job in '14.
Q. What's managed care?
A. Essentially utilization management in the insurance company.
Q. And why would an insurance company want to do utilization management?
A. To make sure the patient is getting the best care.
Q. So this is really a quality control mechanism is what you're telling me?
A. You can, you can call it that. We're not part of the Quality Control Department.

Q. All right. I'm going to attempt to show you --
A. You're going to attempt to what?
Q. -- show you a document.
Can you see that?
A. I see "Ian Cross has started screen sharing" in a big, black screen.
Q. Oh, that's unfortunate.
A. Now I can see it.
Q. Okay. Is this something that you reviewed to prepare for today's deposition?
A. I don't believe so.
Q. Okay.
MR. SCARBER: Could you identify what it is, Ian, for the record, so we'll know in case something happens?
MR. CROSS: This is a page -- we'll call this Exhibit 1. It is a page from the Plaintiff's hard file medical records.
MR. SCARBER: And what date and all that kind of stuff is what I'm --
MR. CROSS: The date is 11-22-2016, 2:04 p.m.
(Deposition Exhibit Number 1 will be marked upon receipt.)
BY MR. CROSS:
Q. So do you see where it says provider?

A. Yes.
Q. Do you know who that person is?
A. Yes.
Q. Who is she?
A. She's a physician that works in a couple other places.
Q. Does she work in prisons?
A. Well, of course.
Q. Okay. And her name is Sharon Oliver?
A. Correct.
Q. Okay. Did Dr. Oliver need to send you a request before she could perform -- well, strike that.
This is a Procedure Consent Form --
A. Correct.
Q. -- for an anoscopy; correct?
A. Correct.
Q. What is an anoscopy?
A. That's where you look inside the anus.
Q. Did Dr. Oliver need to send you a request form before she could perform an anoscopy on this patient?
A. No.
Q. Why not?
A. Because it's an on-site procedure and not an off-site procedure.
Q. I want to direct your attention to the second sentence of the paragraph there. Could you read that for the record?

A. "The specific risks of bleeding, death, failure rate, infection, possible continued pain, possible conversion to open surgery, possible loss of function, repeat procedure were discussed in detail."
Q. So those risks, those are real risks; right?
A. Absolutely.
Q. Those things can actually happen when you undergo an anoscopy; correct?
A. Yeah.
Q. How can an anoscopy result in death?
A. If the rupture of a -- any procedure has a three percent chance of risk, a risk of death, number one.
Q. So --
A. Number two, you can have death from an anoscopy if you cause infection or bleeding. There is no open procedure for anoscopy.
Q. So if an anoscopy is so dangerous, why is Dr. Oliver authorized to do it without your approval?
MR. SCARBER: Just going to place an objection. It's outside the -- it mischaracterizes the witness' testimony. Go ahead.
A. If the provider is able to or, and, and knows how to do an anoscopy, there's no reason why they shouldn't be doing them on site.
BY MR. CROSS:

Q. Why do providers need approval from utilization management for off-site procedures but not for on-site procedures?
A. Because they have to have trans -- one major issue is they have to have transportation and they have to have approval for an off-site visit for transportation.
Q. But didn't you say that utilization management was about making sure the patient gets the best care?
A. Certainly.
Q. So why wouldn't you want to make sure the patient gets the best care with respect to on-site procedures?
A. Who, who is to say they aren't?
Q. Let me understand this. When the doctor wants to send the patient off site for a service, you review that request to make sure that the risks of the proposed service do not outweigh the benefits to the patient; correct?
A. It may -- repeat that question again, please.
MR. CROSS: Can you read the question back, ma'am?
(At 11:37 a.m., record repeated by reporter as follows: "Q. Let me understand this. When the doctor wants to send the patient off site for a service, you review that request to make sure that the risks of the proposed service do not outweigh the benefits to the patient; correct?")
A. I review it to see that it's the best medicine for the

patient. In my medical judgment, I have to be able to say, yes, that is what should be done next.

BY MR. CROSS:

Q. And why would it not be important for you to do that when a dangerous on-site procedure is being performed?

A. An anoscope is a rather benign procedure that is performed by lots of physicians.

Q. How about a colonoscopy? Is a colonoscopy a rather benign procedure that is performed by lots of physicians?

A. No.

Q. So a colonoscopy is more dangerous than an anoscopy?

A. Yes.

Q. Would you agree that in terms of knowing the patient, a doctor who lays their hands on the patient probably knows more about the patient than anybody that hasn't touched the patient?

A. Probably. Yes.

Q. So why wouldn't you defer to the medical judgment of Dr. Oliver regarding whether a patient needs a given off-site procedure?

A. I've already explained that, that sometimes those procedures that are requested are not the best for the patient.

Q. Do you have some information about what's best for the patient that Dr. Oliver doesn't have?

MR. SCARBER: Just going to place an objection. That's been asked and answered.

A. No.

BY MR. CROSS:

Q. So why would you second guess her medical judgment?

A. I'm not second guessing; I'm making a medical judgment as a utilization manager.

Q. What is an ATP?

A. Alternative treatment plan. It's an abbreviation.

Q. Do you sometimes create ATP's rather than approving an on-site physician's request for an off-site service?

A. Yes.

Q. How often do you do that?

A. How often?

Q. Yes.

A. It's right around ten percent of the time.

Q. Ten percent of the time.

And how many of these requests do you review a day again?

A. Probably that depends on the day, that depends on the week, it depends on how many people are off on PTO. I mean I really can't tell you that number.

Q. Well, is it more than ten?

A. Yes.

Q. Is it more than fifty?

A. I'm sure there are days that it is.

(Deposition Exhibit Number 2 will be marked upon receipt.)

BY MR. CROSS:

Q. All right. I'm going to show you another document. We'll call this Exhibit 2.

Do you recognize this document?

A. It's a 407.

Q. Is this a document you reviewed to prepare for today's deposition?

A. Yes.

Q. Okay. I want to direct your attention to the sentence starting on line three of the Signs & Symptoms paragraph.

MR. SCARBER: Hey, Ian, I don't want to interrupt you, but you've got to identify the, you know, exhibit, like the date. There's a couple of -- there's a bunch of 407's in this case. So --

MR. CROSS: So --

MR. SCARBER: -- you can just say this is dated whatever and that's fine. At least I'll know.

MR. CROSS: Request dated January 6th, 2017; is that fair?

BY MR. CROSS:

Q. I want to direct your attention to the second sentence on line three of the Signs & Symptoms paragraph.

Could you read that for us?

A. "He was found to have FOBT positive on 11-8, 11-9, 11-17, 11-18, 11-22. He complained of epigastric pain."

Q. Okay. What is FOBT? What does that mean?

A. That means that they found occult blood in his stool. Occult, o-c-c-u-l-t.

Q. Why is that something you would test for?

A. To evaluate whether the patient has blood in his stool.

Q. Why would a doctor need to know if there's blood in a patient's stool?

A. We test them yearly for FOBT's for blood in the stool as colorectal cancer screening.

Q. So you're saying that the reason you would test for blood in a patient's stool is to screen for colorectal cancer?

A. Not the only reason.

Q. What other reasons might you test for blood in a patient's stool?

A. If a patient complains of blood in the stool; if the patient has anemia.

Q. I'm sorry. Go ahead.

A. If the patient has anemia.

Q. You would agree that blood in a patient's stool could indicate that the patient has colorectal cancer?

A. It could. It could also --

MR. SCARBER: Finish your answer.

A. It could also indicate that the patient has eaten meat or beets, or somebody read the FOBT test wrong.

BY MR. CROSS:

Q. All right. I want to direct your attention to the last paragraph in the Signs & Symptoms -- or the last sentence in the Signs & Symptoms paragraph. I'm sorry.

Could you read that for the record?

A. "Now with increasing numbers of stools, six to seven times a day with BRB, and he has a seven-pounds weight loss since December of '16."

Q. What's BRB?

A. Bright red blood.

Q. Isn't blood always bright red?

A. No.

Q. When is blood in the stool not bright red?

A. Typically when it's a stomach bleed, it's black.

Q. What is melena?

A. Black stools.

Q. What does that indicate about the source of the bleeding?

A. Did this case have melena?

Q. Can you just answer my question?

A. Yeah.

MR. SCARBER: Object to relevance, but go ahead.

A. Black stools typically or -- no -- may indicate that the patient has bleeding in his stomach, it may indicate that

he's used Pepto Bismol, and it may even be indicated, may be found in patients who eat red meat.

BY MR. CROSS:

Q. And what does bright red blood in the stool indicate?

A. Bleeding further down the stool, down the colon.

Q. Okay. What are some -- do you see where it says Failed Outpatient Therapies here on the form?

A. I do.

Q. Do you know what that means?

A. It means that the provider believes that these are Failed Outpatient Therapies.

Q. What's a Failed Outpatient Therapy?

A. A therapy that has not worked the way the provider thinks it should have.

Q. Why is it important for the provider to put Failed Outpatient Therapies on the 407?

A. So that I don't look for those therapies -- or look for those problems.

Q. Okay. So can you read the first line of the Failed Outpatient Therapies, for the record?

A. "Anoscopy: Perirectal area normal to inspection and palpation."

Q. And the second sentence?

A. "No hemorrhoids, fissures or condylomata."

Q. What's a hemorrhoid?

A. It's essentially a varicose vein in the anus.

Q. Why would it be important to check for hemorrhoids in this patient?

A. Because bright red bleeding may be coming from his hemorrhoids.

Q. What's a fissure?

A. A fissure is essentially a tear in the anus.

Q. And why would you check for fissures in this patient?

A. Bright red bleeding.

Q. What is that last word in that sentence?

A. Condyloma?

Q. Yeah. What is that?

A. Human papillomavirus warts.

Q. And why would we check for human papillomavirus warts in this patient?

A. Well, typically they're external, they don't bleed very much, and they're just part of a complete exam.

Q. Do you see, below that paragraph, where it says "Protonix"?

A. Yes.

Q. What's Protonix?

A. It's a PPI, what you asked about earlier.

Q. Yes. PPI is a proton pump inhibitor?

A. Correct.

Q. And the proton pump inhibitor I believe you testified

would reduce the level of acid in the patient's stomach?

A. Correct.

Q. So why would you prescribe Protonix for this patient?

A. I didn't.

Q. Do you believe it's an appropriate drug to treat this patient's symptoms?

A. If the patient was having epigastric tenderness, yes, and you'll see that he does.

Q. Would Protonix do anything for this patient's bright red blood in his stool?

A. Probably not.

Q. Okay. What are some possible causes of bright red blood in the stool?

MR. SCARBER: Asked and answered I believe maybe twice, but go ahead.

A. Bright red blood in the stool, it would be a fissure, it would be hemorrhoids, it could be constipation, it could be a polyp. It actually has been found that there are some people that have bright red blood in their stool from a gastric ulcer, ulcerative colitis, Crohn's disease, and that would be the top diagnoses.

Q. How about bowel perforation?

A. Typically bowel perforation does not cause bright red bleeding in the stool; it causes internal bleeding.

Q. How about cancer?

A. Well, that would be polyps, but yes.
Q. Are you able to determine, from the information contained in this 407 request, the source of the patient's rectal bleeding?
A. No.
Q. What information would you need to be able to determine the source of the bleeding?
A. Find out if the patient is constipated, then clear the constipation, then do a, probably do a colonoscopy.
Q. So a colonoscopy would be necessary to determine why this patient has been passing blood in his stool?
A. Not necessarily. You can pass blood and have a normal colonoscopy.
(Deposition Exhibit Number 3 will be marked upon receipt.)
BY MR. CROSS:
Q. All right. I'm going to direct your attention to another document. We'll call this Exhibit 3.
Do you recognize this document, sir?
A. 11-22-16. It's a 407.
Q. Is this a document you reviewed to prepare for today's deposition?
MR. SCARBER: I'm going to place another objection. If you can identify what the exhibits are when you refer to them, that would be helpful.

A. I would have to see the bottom of this to find out if I reviewed this or not.
BY MR. CROSS:
Q. (Indicating.)
A. Yes, I did.
Q. And this is a Michigan Department of Corrections Consultation Request Form submitted 11-22-2016.
So in the comments right below the name of this individual, Kaelynn Pfeil, could you read that, for the record?
A. "Request colonoscopy to evaluate rectal bleeding."
Q. And the reviewer comments down here, would you read that?
A. "ATP: Medical necessity not demonstrated at this time. Clear constipation, consider utilizing Senna 8.6 milligrams up to 2 tabs twice a day scheduled not PRN, and reevaluate at the time that the abdominal films demonstrate resolution of constipation."
Q. What does that mean?
A. That means clear his constipation and prove that it's cleared.
Q. And then do what?
A. Then you can reevaluate the patient. I can then look at whether a colonoscopy is warranted.
Q. So why did you issue this ATP instead of approving this request for a colonoscopy?

A. First of all, if he's constipated, you can't do an adequate colonoscopy in a constipated individual. You have to clear the constipation and prove it's been cleared.
Second, in the prison population, constipation is a horrible problem and, unfortunately, that is more common than any of the other reasons for bright red bleeding in the population.
Q. All right. So I want to go back to this Exhibit 2, the January '17 request.
And what does it say in the Lab & X-ray Data, starting on the third line?
A. "X-ray abdominal: Multi-view abdomen revealed the visceral outlines to be unremarkable. The gaseous pattern appeared to be normal. No evidence of calculi could be seen in the region of the kidneys, ureters or urinary bladder. No constipation was seen."
Q. And what's the date on that?
A. 12-8.
Q. 12-8-16?
A. Correct.
Q. So Exhibit 3, which we just looked at, this November 16 request, it looks like they did what you told them to do; they cleared the constipation and proved clearance with an X-ray; correct?

A. I would have to see the X-ray.
Q. So this Lab & X-ray Data here where it says "no constipation was seen", that's not sufficient?
A. No. It's not sufficient. I would see the X-ray report.
Q. Do the requests you review typically come with an X-ray report?
A. Sometimes; most of the times, I have to ask for it.
Q. Did you ask for the X-ray report on this occasion?
A. I assume so, but --
Q. I'm sorry. I didn't hear that.
A. I said I assume so, but I don't -- I can't recall. My medical judgment would say get the X-ray.
Q. What are your options in responding to a 407 request?
A. Approve, defer, or ask for more information.
Q. Did you approve, defer, or ask for more information for this request?
A. I don't know. I would have to see the bottom.
Q. (Indicating.)
A. I ATP'd it.
Q. Why didn't you ask for more information?
A. I may have had the X-ray.
Q. Can you read your ATP, for the record?
A. "Medical necessity not demonstrated at this time. When symptoms demonstrate medical necessity, resubmit."
Q. What's medical necessity?

A. Do we need an off-site that can't be contained -- excuse me -- do we need an off-site visit that can't be done on site.
Q. Can a colonoscopy be done on site?
A. No, but further workup can be.
Q. So what further workup did you order in this ATP?
A. I had already ordered it to clear the constipation and prove that it was cleared.
Q. And why doesn't this Lab & X-ray Data indicate that they have done that?
A. Well, the lab information says he's not anemic, which is unusual in somebody who, quote, has blood in every stool. The abdominal film I would've had to see. So either I didn't see it or the lab data does not support or something else.
Q. But you're not able to determine -- strike that.
When would symptoms demonstrate medical necessity?
A. If he continued to have problems.
Q. Do you know how long this patient had been having bright red blood in his stool at this point?
A. Yeah, since November, he had bright red blood as a subjective observation.
Q. What do you mean by that?
A. I mean that he told them that he's been having bowel

movements with bright red blood since November. He --
Q. Is there any reason not to believe him?
MR. SCARBER: You know, I think the doctor is trying to finish a couple of the answers and I think because of the delay, you think he's finished; is that true?
THE WITNESS: That's true.
MR. SCARBER: It's not your fault, Ian; it's just the way that this is happening. Go ahead. Finish your answer.
A. I can't remember what I was going to say.
MR. SCARBER: Court Reporter, Madam Court Reporter, can you repeat back the answer -- the last question and answer?
(At 12:02 p.m., record repeated by reporter as follows: "Q. What do you mean by that?
A. I mean that he told them that he's been having bowel movements with bright red blood since November. He --")
A. So that does not mean that he has had bright red blood, it means that he thinks he has had bright red blood, and the lab tests certainly don't lean towards that, with a normal hemoglobin.
BY MR. CROSS:
Q. Can you read the first sentence on the second line of the Signs & Symptoms on this request?
A. The one that begins with "he was found"?
Q. Yes.
A. "He was found to have FOBT positive on 11-8, 11-9, 11-17, 11-18 and 11-22.
Q. Are those subjective reports?
A. Yes, they are.
Q. Why are they subjective?
A. Well, they're subjective from a physician's standpoint.
Q. How about, "On 12-20-16 he returned three FOBT positive cards, after clearing constipation"?
A. Yeah.
Q. Is that subjective?
A. Okay. FOB can be positive for several reasons. One is blood; two is anything he ate that had blood in it; three is anything that causes his stool to be black; or a misread of the FOBT cards. The FOBT cards are read by nursing staff, typically. I don't know if these were read by a physician or not.
Q. So we have I think here eight FOBT positive cards in the Signs & Symptoms and you're assuming that all of them were misread?
A. No. I didn't say misread.
Q. So when you received this request, did you doubt that Mr. Lyles actually had bright red blood in his stool?

A. I don't know that I doubted it. I noted that his hemoglobin was 15.4, which is rather normal for a male, and somebody who had been bleeding significantly would not have a hemoglobin of 15.4.
Q. So why would we even test with these FOBT cards?
Why don't we just do hemoglobin tests to determine if people are bleeding rectally?
A. Doing a hemoglobin test will not tell you that a patient is bleeding rectally. There are more anemias than anemias caused by rectal bleeding.
Q. But any anemia caused by rectal bleeding would result in a low hemoglobin level?
A. That's what anemia is.
(Deposition Exhibit Number 4 will be marked upon receipt.)
BY MR. CROSS:
Q. All right. We'll call this Exhibit 4. I'm going to show you another document. It is a request dated 12-22-2016.
Is this something you reviewed to prepare for today's deposition?
A. You have to drop down a little bit.
Q. (Indicating.)
A. Yes.
Q. How did you respond to this request?
A. ATP'd it.

Q. What was your --
A. I beg your pardon?
Q. What was your ATP?
A. "Medical necessity not demonstrated at this time. Treat constipation with scheduled Senna and prove clearance with abdominal films and reevaluation" -- excuse me -- "and reevaluate."
Q. Is that any different than your November 2016 ATP?
A. I don't know. I'd have to see it.
Q. All right. Let's go to Exhibit 3.
A. It is different.
Q. How is it different?
A. I asked for abdominal films, demonstrate resolution of constipation in the November 22 note.
Q. And then in the December 22, did you request that they prove clearance with abdominal film?
A. No. That was already requested in the previous ATP.
Q. I guess what I'm getting at is did you request the same thing again?
A. I did not request abdominal film for resolution of the constipation on the second one; I did request abdominal film for resolution of the constipation on the first one.
Q. All right. Can you read -- we're looking at the 12-22-2016 ATP?
A. Yes.

Q. Can you read the ATP, second sentence?
A. I already did. "Medical necessity not demonstrated at this time. Treat constipation with scheduled Senna 8.6 milligrams" -- excuse me -- "8.6, 2 tabs, BID, prove clearance with abdominal film" -- oh, I guess I did -- "and reevaluate."
Q. Isn't "prove clearance with abdominal film and reevaluate" the same thing you requested a month before?
A. Yeah, but it was in different wording. I'm sorry.
Q. So why did you give them the same ATP that they had just done?
A. Because it still says constipation.
Q. Can you read the second sentence of the last Lab & X-Ray Data on, this is the December '16 ATP?
A. Sure. Wait a minute. That's December 22nd.
Q. We have a November, we have a December, and we have a January, so right now we're on the December.
A. It says, "Multi-view abdomen revealed the visceral outlines to be unremarkable. The gaseous pattern appeared normal. No evidence of calculi could be seen in the region of the kidneys, ureters or urinary bladder."
Q. So what does it mean that the visceral outlines appeared to be unremarkable?
A. That they can see the bowel.
Q. What does it mean that the gaseous pattern appeared normal throughout?
A. That he had the correct amount of gas in his colon.
Q. What's the clinical significance of that?
A. Well, you can have the correct amount of gaseous patterns appearing normal throughout with constipation. There's nothing in this that says constipation is cleared.
Q. All right. So if we go to the January '17 response, that does say constipation was cleared; correct?
A. It depends on who read it.
Q. What'd you say?
A. I said it depends on who read the X-ray.
Q. Well, what they reported to you in the request form was that there was no constipation; right?
A. And we have a radiologist, at that time in 2016, that was reading no constipation with constipation. Right.
Q. All right. I want to direct your attention to the top of this form.
Do you see where it says, "Third-Party insurance (VA, Workmen's Comp, Federal, Interstate Compact)?
A. Yes.
Q. Do you know what Interstate Compact means?
A. No. It's an insurance company.
Q. It's an insurance company?
A. Wait. Third-party insurance means, "Are there any?" You see the colon at the end of the line and it says "MDOC".

Q. Okay. And VA, Workmen's Comp, Federal, Interstate Compact, those are potential insurance companies?
A. As far as I know. That's how I read it.
Q. That's how you read it?
A. Yes. And there is no "etc." insurance company. It's a list of insurance companies, and the one he's covered by is MDOC.
Q. Why is it important to list the insurance company that he's covered by on the 407?
A. I don't know.
Q. You have no idea at all?
A. No. I have no idea at all.
Q. Do you have any idea what --
A. It makes no -- it makes no --
Q. Go ahead.
A. It makes no difference to me.
Q. Do you have any idea what the passthrough list is?
A. Yes.
Q. What's the passthrough list?
A. It's a list of procedures that can be approved without my seeing them.
Q. Do you contribute to determining what procedures are on the passthrough list?
A. I'm part of the department, and the department makes those decisions.

Q. Are procedures paid for, by workmen's comp, on the passthrough list?
A. I have no idea. I have no idea who pays for any of it.
Q. Do you receive performance evaluations in your job, sir?
A. Yes, on how long it takes me to do a procedure -- or do an approval.
Q. Is a portion of your annual performance eval based on the percentage of requests that you ATP?
A. Absolutely not.
Q. It is not?
A. It is not.
(Deposition Exhibit Number 5 will be marked upon receipt.)
BY MR. CROSS:
Q. All right. I'm going to direct your attention to another document. We'll call this Exhibit 5.
Do you recognize this document?
A. Yes. It is a, it is a curriculum vitae, my experience, and what's going on, what's happening with the patient.
Q. I'm sorry. What was that?
A. It's my experience and what my job is.
Q. Okay. So see this Key Accomplishments section right here?
Can you read your first Key Accomplishment, for the record?
A. "Worked with providers one-on-one and increased approval

rate for outpatient consult requests to ninety percent consistently."
Q. What does that mean?
A. That means that I approved ninety percent of what comes across my desk.
Q. Well, how did you work with providers one-on-one to increase their approval rate?
A. If they're putting in for things that don't, that aren't necessary or aren't going to increase the medical care of the patient, then I call them and tell them.
Q. So the providers of the prisoners should not be requesting things that are not medically necessary?
A. Correct.
Q. So do you believe that this request, Exhibit 1, for a colonoscopy for Mr. Lyles was inappropriate?
A. Can you go back to that, please, so I can see it?
Q. (Indicating.)
A. That is not for a colonoscopy; that is a request for a GI consult. We don't need a GI consult to do a colonoscopy.
Q. How about this one? Is this a request for a colonoscopy?
A. I can't see.
Q. (Indicating.)
A. Yes, it is.
Q. The November 2016 request?
A. Yes, it is.

Q. And do you believe that was inappropriate?
MR. SCARBER: Just going to place an objection. Mischaracterizes his testimony. All he said was he didn't believe it was medically necessary at the time. Go ahead.
A. At the time, the constipation was the issue because more of our patients have constipation than have problems necessitating a colonoscopy. So we go about finding the easiest and most obvious problem first and get that out of the way of our diagnostic workup.
BY MR. CROSS:
Q. So after you had gotten that out of the way, for example, the next month, you also deferred, correct, again?
MR. SCARBER: Going to place an objection. Outside the -- misquoting the doctor's testimony, or misrepresenting, but go ahead.
A. Yes. I deferred it again because it wasn't completed the first time.
BY MR. CROSS:
Q. And then in January '17, you deferred it again; correct?
MR. SCARBER: Asked and answered.
A. Yes, I did.
BY MR. CROSS:
Q. How is Dr. Oliver supposed to know when the symptoms demonstrate medical necessity?
A. She is a physician.

Q. Well, in her medical judgment, she believed Mr. Lyles should have an off-site visit; correct?
MR. SCARBER: Just going to place an objection. Calls for foundation. He doesn't know what people -- or what she actually believed. He's not her. You can try to answer the question if you understand it.
A. I don't know that I can answer it. Yes. I deferred it and it was because we have not gotten our -- does that mean anything, that you changed the host?
BY MR. CROSS:
Q. What?
MR. SCARBER: Court Reporter -- no, okay. I think the screen quit and he got sidetracked because our screen switched. I'm sorry. I think the people -- something on the screen moved or switched around and I think he got stuck in his answer.
Okay. So maybe repeat the question or repeat his answer so he can figure out what he left off. I'm sorry. Court Reporter, can you read back his answer so he can figure out where he stopped? Sorry.
(At 12:24 p.m., record repeated by reporter as follows: "A. I don't know that I can answer it. Yes. I deferred it and it was because we have not gotten our -- does that mean anything, that you changed the host?")

THE WITNESS: Yeah. Stop changing the host.
A. Anyway, in my medical judgment, we needed to go get rid of the constipation. And a very large percentage of the time you clear the constipation in this group, the patient gets better, which did happen in this case.
BY MR. CROSS:
Q. What was the last thing you just said?
A. And it did, and it did happen in this case.
Q. This patient got better?
A. Yes.
Q. So you think you made the right decisions with those three requests we discussed today?
A. Absolutely. In my medical judgment, I made the right decision.
Q. Are you aware that Mr. Lyles has ulcerative colitis?
A. Yes. And he got a colonoscopy that showed he had ulcerative colitis.
Q. Do you know when he got a colonoscopy that showed he had ulcerative colitis?
A. I do not offhand.
Q. Do you know approximately when?
A. It was in the early summer, as I recall.
Q. I'm going to direct your attention to this paragraph at the bottom of the 407 request form. It says, "Note: Notify physician or midlevel practitioner immediately if

unable to obtain an appointment within four weeks. If service is not completed within four weeks, have patient reevaluated by physician or midlevel practitioner to determine if service is still necessary and appropriate."
Is it common that if a service, that you do not approve, cannot be performed within four weeks --
A. It depends on the --
Q. -- if they --
COURT REPORTER: Are two people talking at the same time? I don't want to miss anything.
MR. SCARBER: Yes, they were. I didn't object. This was one of those instances of pausing. The doctor was answering. I think he started saying "it depends" and then Mr. Cross came in with his question as he was answering, not intentionally but because of the delay. But go ahead and finish your answer if you can pick up.
A. Yes. There are many times procedures that are approved cannot be done in four weeks.
BY MR. CROSS:
Q. Is it important to promptly diagnose ulcerative colitis?
A. It's important to diagnose anything.
Q. Is it important to promptly diagnose cancer?
A. Of course.
Q. And rectal bleeding could be caused by ulcerative colitis, Crohn's disease, cancer?

A. I would agree with that. Yes.
Q. So delaying the diagnosis of those serious medical conditions could cause harm to a patient?
MR. SCARBER: And let me place an objection to relevance and foundation. We know what Mr. Lyles' situation was -- but go ahead, Doctor -- and it wasn't everything counsel mentioned, but go ahead.
A. Yes. It's important to get diagnosed, get cancer diagnosed. It's important to get anything diagnosed so that we aren't having to continue to do workup. The concern is there are explicit risks to a colonoscopy, and so we're getting rid of the things that can cause the same symptoms, i.e., constipation, before we go to a colonoscopy.
BY MR. CROSS:
Q. Did you review any medical literature when issuing your ATP's for Mr. Lyles in these three instances?
A. I, I don't believe so. It's purely medical judgment.
Q. Do you remember what you reviewed?
MR. SCARBER: Just going to place an objection. I think he said he didn't, he doesn't believe he reviewed any, any literature or something like that.
MR. CROSS: I asked him if he remembers what he reviewed.
A. And I said I didn't. There was no need to in this case.

BY MR. CROSS:
Q. So you do remember what you reviewed or you don't remember what you reviewed?
MR. SCARBER: Let me just object and note the confusion. I think he's thinking you're talking about literature, but go ahead.
A. This is a very common problem and typically handled always the same way, so I do not know if I reviewed any new literature.
BY MR. CROSS:
Q. Do you know what UpToDate is?
A. Of course.
Q. What's UpToDate?
A. It's a group of specialists' opinions on what to do next.
Q. Do you use UpToDate to do your job?
A. Yes.
Q. How do you use it?
A. I use it when I do not understand what's going on. When my medical judgment says that I see what's happening, I don't need to go to UpToDate.
Q. So you understood what was going on with Mr. Lyles in late 2016 and early 2017?
A. I understood that the man had constipation that needed to be removed from the diagnostic list.
Q. Did you understand that he was passing bright red blood

from his rectum?
MR. SCARBER: I'm just going to place an objection. He's asked and answered what his understanding was about that in very great detail before, step by step, but go ahead.
A. I understood that the patient was complaining of bright red bleeding, with a normal hemoglobin and constipation.
BY MR. CROSS:
Q. And did you understand that constipation was cleared per your orders?
MR. SCARBER: Just going to place an objection, asked and answered, gone into great detail about constipation, when it was cleared, what his understanding was. Go ahead.
A. Do I need to answer that question again?
BY MR. CROSS:
Q. You do have to answer the question unless your attorney specifically tells you not to answer it.
A. Are you looking at the -- are you discussing the 12-8 X-ray?
Q. Yes.
A. As I said earlier, it would depend upon who read that X-ray.
Q. So you're doubting the accuracy of the radiologist?
A. No, I am not. I know the radiologist, I know how he

reads, and he doesn't believe that he can read constipation from an X-ray.
Q. So if he can't read constipation from an X-ray, why did you order an X-ray to determine if Mr. Lyles was still constipated?
A. There are two radiologists reading X-rays and I would have asked the second to read it.
Q. So the other radiologist would be able to tell?
A. Well, the other radiologist does not have a feeling that constipation cannot be read from an X-ray.
Q. Who are the two radiologists?
A. Dr. Henderson and Dr. Mindlin.
Q. And which one feels that constipation cannot be read from an X-ray?
A. Well, he doesn't any longer, that was what it was back then, and that would be Mindlin.
Q. Do you agree with Mindlin that constipation cannot be read from an X-ray?
A. Absolutely not.
Q. So why wouldn't you trust this X-ray data that says no constipation was seen?
A. Because I believe it was read by Dr. Mindlin.
Q. Can you tell, from the 407 request, which radiologist read the X-ray?
A. No. That's why I told you earlier I would have to see the

X-ray report.
Q. But you don't know if you actually did request the X-ray report?
A. I did not request the X-ray report; I probably went and looked at it.
Q. And then you saw that it was read by Dr. Mindlin?
MR. SCARBER: Just going to place an objection to asked and answered.
A. (No response.)
BY MR. CROSS:
Q. Who's the other doctor -- I'm sorry -- who reads X-rays?
A. Dr. Henderson.
Q. Henderson. So if we were to request the X-ray report in discovery, would we be able to tell from the report which radiologist read it?
A. Absolutely.
Q. Okay. Did you receive any written discovery responses in this case?
A. What is that?
MR. SCARBER: Can you rephrase your question, counsel?
BY MR. CROSS:
Q. Did you receive any interrogatories in this case?
Do you know what a interrogatory is?
MR. SCARBER: Answer his question. He's talking

about the discovery answers. Go ahead.
A. Yeah. I believe we had them; didn't we? I don't know.
BY MR. CROSS:
Q. Okay. I'm going to show you what we will --
MR. CROSS: What exhibit are we on; 6?
COURT REPORTER: The curriculum vitae was Exhibit 5, if that's the last one you remember marking.
(Deposition Exhibit Number 6 will be marked upon receipt.)
BY MR. CROSS:
Q. Exhibit 6. So is that your signature there, sir?
A. Yes.
Q. And you signed these responses declaring, under penalty of perjury, that the foregoing are true and correct?
A. Correct.
Q. All right. I want to direct your attention to the first interrogatory. I asked, "What criteria and/or information do you use to determine whether a given test, procedure, or off-site referral is medically necessary?"
And you said, "In the present matter, no specific policy or criteria was used in the present matter"; correct?
A. I think you're off one response.
Q. Am I?
A. Oh, you're talking about the last one? There was no

reason to go look anywhere.

MR. SCARBER: Listen to his question and see what he's trying to ask. Is that what your answer says, what he just read? And we can get into what you mean and all that kind of stuff based upon the question, but did he read your answer correctly?

THE WITNESS: Yeah. He read it correctly, yeah, off the form.

MR. SCARBER: Okay.

BY MR. CROSS:

Q. So there's no specific policy or criteria that was used to determine whether any of the tests, procedures, or off-site referrals in this case were medically necessary?

A. It all, it all comes down to what I deem, in my medical judgment, needs to be done. I did not -- never mind.

Q. What? I'm sorry? What was that?

A. I didn't say he didn't need a colonoscopy; I said he needed to have his constipation cleared.

Q. When you say that a requested off-site procedure is not medically necessary, that is not medically necessary for what?

A. At this time.

Q. So when you used the word necessary, what are you referring to? Necessary to prevent some kind of harm? Necessary for the patient's comfort? What is that?

A. Well, it isn't for the patient's comfort. It is for whether it's necessary to be done at this time.

Q. Okay.

MR. SCARBER: And I'm going to place an objection to asked and answered earlier a couple of times at different places.

BY MR. CROSS:

Q. So if a procedure is necessary to prevent death, would that procedure be medically necessary?

A. It depends on --

MR. SCARBER: I'm going to place an objection. Wait. Go ahead.

A. It depends on the situation.

MR. SCARBER: And I'm going to object to foundation. It's not a real hypothetical.

BY MR. CROSS:

Q. So sometimes procedures that are necessary to prevent death are not medically necessary?

MR. SCARBER: Mischaracterizes his testimony.

A. I don't believe that's what I said to you.

BY MR. CROSS:

Q. You said it depends on the situation; right?

A. Correct.

Q. And I asked you if a procedure that is necessary to prevent death is medically necessary?

A. It depends on when it's asked for. It depends on supporting data. There's -- that can't be answered.

Q. What do you mean it can't be answered?

A. That's a hypothetical question. It has nothing to do with this case.

Q. Well, I'm asking it.

MR. SCARBER: I'm going to place an objection. I mean it's a, it's a very broad question. It's not delineated with any type of facts and circumstances whatsoever. The question is is a procedure that's necessary to prevent death medically necessary? What kind of procedure? There's all kinds of procedures that, you know, where they may not be appropriate, depending on what the circumstances are, even in a situation like that, so I don't, I don't really understand the question myself.

BY MR. CROSS:

Q. I guess when we're saying something is medically necessary or it's not medically necessary, medically necessary for what?

MR. SCARBER: Asked and answered many times.

BY MR. CROSS:

Q. Go ahead.

A. I don't know what else I can tell you. I have told you what it means.

Q. How about a liver transplant for a patient with endstage

liver disease, is that medically necessary?

MR. SCARBER: It's hypothetical and it has nothing to do with this case. Mr. Lyles does not have endstage liver disease.

BY MR. CROSS:

Q. Well, I'm just trying to understand what you mean when you say that a gastroenterology consult or a colonoscopy for Mr. Lyles are not medically necessary.

A. I have explained that.

Q. Do you think that Mr. Lyles could benefit from a gastroenterology consult?

A. An off-site visit is approved; you can't do it on site. And everything that we were working on could be done on site. There was no reason for a gastric --

Q. So could you -- go ahead. I'm sorry.

A. There was no reason for a gastroenterology consult at that time.

MR. SCARBER: Hey, Ian, maybe give him a two-second pause or something and that way you'll know he's done before you chime in --

MR. CROSS: Okay.

MR. SCARBER: -- to the best of your ability. I know it's difficult.

BY MR. CROSS:

Q. So could you do a colonoscopy on site?

MR. SCARBER: Asked and answered.
A. I already told you no, they can order it on site. They don't need a GI consult to order a colonoscopy.
BY MR. CROSS:
Q. So why wasn't your ATP, in January, colonoscopy?
A. Because I didn't have the information that I needed to prove that the colonoscopy, that the colonoscopy could be done without a problem from the constipation.
Q. Well, what did you want them to do for Mr. Lyles instead of a colonoscopy or gastroenterology consult in January of 2017?
MR. SCARBER: Well, I'm going to place an objection because I think he's definitely gone through this probably for about ten, fifteen minutes or more, but go ahead. I mean we're gonna rely on his testimony every time you ask the same question, but go ahead.
A. Can you read me the question back, please, Court Reporter?
COURT REPORTER: Do you want me to read it back, Mr. Cross?
MR. CROSS: Yes. Go ahead.
(At 12:46 p.m. record repeated by reporter as follows: "Q. Well, what did you want them to do for Mr. Lyles instead of a colonoscopy or gastroenterology consult in January of 2017?")
A. I think I was clear. Clear the constipation, make sure

the constipation is cleared and reevaluate the patient, reevaluate the patient to see if he needed anything more.
BY MR. CROSS:
Q. So then why does this ATP not request that they clear his constipation and make sure the constipation is cleared?
A. Because I had already done it twice and, thus, they had reviewed that, those two ATP's, and knew exactly what I needed.
Q. And you don't believe they did that?
A. I don't believe they did what?
MR. SCARBER: Form, foundation, and asked and answered.
BY MR. CROSS:
Q. Gave him Senna twice daily, verified clearance with abdominal film?
MR. SCARBER: Asked and answered. Go ahead.
A. They had a film that was questionable, in my mind.
BY MR. CROSS:
Q. And that's why you ATP'd this request?
MR. SCARBER: Form --
A. I --
THE WITNESS: Oh, I'm sorry. Go ahead.
MR. SCARBER: Asked and answered, as to why he ATP'd this, many times, but go ahead.
A. I ATP'd this because I wasn't sure that the constipation

had been cleared.
BY MR. CROSS:
Q. Why didn't you write that in your ATP?
MR. SCARBER: Asked and answered. You just asked him why he didn't write the same thing he wrote before.
A. (No response.)
BY MR. CROSS:
Q. You wrote, "When symptoms demonstrate medical necessity, resubmit".
So we're waiting for symptoms to necessitate medical necessity; correct?
A. Correct.
Q. And when would symptoms demonstrate medical necessity?
A. When there is no constipation, when the patient has been reevaluated, if the reevaluation showed that the patient does need a colonoscopy, he certainly would get it.
Q. Well, what would the reevaluation consist of?
A. Physician seeing the patient in the office and reviewing labs, everything.
Q. What are the risks associated with a colonoscopy?
A. Rupture.
Q. Uh-hum.
A. Death.
Q. Uh-hum.

A. Anaphylaxis to the medications used in a colonoscopy.
Q. What are the risks of leaving ulcerative colitis untreated?
MR. SCARBER: I think that was asked and answered, too, but go ahead.
A. It does not cause any more -- any worsening of the condition.
BY MR. CROSS:
Q. What are the risks of leaving colon cancer untreated?
MR. SCARBER: Foundation.
A. Did this case have colon cancer?
MR. SCARBER: Just, just answer the best you can. It's hypothetical, it sounds like.
A. Yeah, it's hypothetical. There's no colon cancer in this case and the risk of not treating colon cancer could be myriad but they may not be.
BY MR. CROSS:
Q. When you say they could be myriad, what does that mean?
A. That means there could be many things that happen because it wasn't treated.
Q. Are you being sued by any other prisoners besides Mr. Lyles?
MR. SCARBER: I'm sorry, Ian. I didn't hear the first part of your question. What did you say?
BY MR. CROSS:

Q. Are you being sued by any other prisoners besides Mr. Lyles?
MR. SCARBER: I'm going to object to relevance. I think you said sued?
MR. CROSS: Yes.
MR. SCARBER: Okay. I'm going to object, I'm going to object to relevance and undue prejudice; but for purposes of discovery, you can answer.
A. I don't understand how that relates to anything to do with this case.
MR. SCARBER: You can still answer the question for purposes of a dep.
THE WITNESS: Oh. The question am I being sued?
MR. SCARBER: Yes.
A. Yes. That comes with the territory.
BY MR. CROSS:
Q. Do you know how many prisoners are suing you?
A. No, I do not.
Q. Were you ever sued before you started working in prisons?
MR. SCARBER: I'm going to place an objection to relevance and undue prejudice and no probative value, but go ahead.
A. Yes.
BY MR. CROSS:
Q. How many times?

A. Twice.
Q. How many times have you been sued since you started working in utilization management?
A. I do not know.
(Deposition Exhibit Number 7 will be marked upon receipt.)
BY MR. CROSS:
Q. All right. I'm going to show you another document. We'll call this Exhibit 7. I want you to read this paragraph starting with "I", for the record.
MR. SCARBER: Hang on a minute. Can you identify for the Court exactly what you want him to read, please, and let the record reflect that this is -- go ahead.
MR. CROSS: The paragraph starting with "I".
MR. SCARBER: What is it that you want him to read? What is the document? Hang on before you answer it.
MR. CROSS: It is a opinion in Pope v. Corizon Health, Keith Papendick, et al.
MR. SCARBER: Can you go back up to the top?
MR. CROSS: (Indicating.)
BY MR. CROSS:
Q. Go ahead.
MR. SCARBER: Okay. So this is a -- I'm going to place an objection. This is a pending case. This

isn't a final, an actual final opinion. This case is still pending.
MR. CROSS: I'm just --
MR. SCARBER: So for him to comment, for him to comment on an ongoing lawsuit is inappropriate and objectionable, and I'll probably only allow very limited questioning on this because I think I'm well within my right to instruct him not to answer on this stuff.
BY MR. CROSS:
Q. Go ahead.
MR. SCARBER: What do you want him to do?
MR. CROSS: I want him to read the paragraph starting with "I".
A. Are you talking about the number one?
BY MR. CROSS:
Q. Yes.
MR. SCARBER: It's Roman Numeral I.
BY MR. CROSS:
Q. Roman Numeral I.
A. Roman Numeral I: "As the Court noted in its screening opinion, the case focuses on events that occurred while Pope was incarcerated at Women's Huron Valley" -- or excuse me -- "WHV."
MR. SCARBER: All right. That's as far as we're gonna go with it. Don't read any more. It's a pending

lawsuit. I'm not letting him comment on it. You can get an order, you can get an order from the Court if you want to have him comment and read opinions on pending lawsuits.
BY MR. CROSS:
Q. Are you aware that you're a Defendant in this lawsuit?
A. I could be.
Q. Do you know what it's about?
A. No, I do not.
Q. No idea what the allegations are at all?
MR. SCARBER: Same objection. Don't answer any more. We'll get a protective order if it continues.
BY MR. CROSS:
Q. All right. I'm going to go back to the interrogatories. I believe this was Request to Produce or -- I'm sorry. It's Exhibit 6, Interrogatory --
MR. SCARBER: Hang on one second, too. Now that I understand what you were doing, I'm gonna move to strike this Exhibit 7 as well. Go ahead, Doctor.
THE WITNESS: I haven't got a question.
MR. SCARBER: No. He's back to another exhibit.
MR. CROSS: We're talking about something else.
THE WITNESS: Correct. And I don't have a question, so I can't go ahead.
MR. SCARBER: Okay. I'm dealing with my objection. Listen to his question and then answer.

BY MR. CROSS:
Q. So Interrogatory 3, we asked if between January 1, 2016 and January 1, 2018 you ever communicated with a medical provider at a Michigan prison concerning the percentage of that individual provider's 407 requests that are ATP'd, and you indicated that you had not; correct?
A. Correct.
Q. And that's true you have not done that?
A. There were reports put out every month that showed the providers how many requests they had, how many were ATP'd, and how many were deferred -- or I mean were NMI'd.
Q. And you discussed those reports with the providers?
A. No. They were sent to them. Their regional medical directors discussed them and that would've --
Q. Did you ever -- I'm sorry. Go ahead.
A. I'm sorry. That would've been only until mid 2017.
Q. Only until mid 2017?
A. Correct.
Q. So after January 1, 2016?
A. Between January 1, 2016 and early 2017, I produced reports of what was going on. They were --
Q. And what was -- sorry. Go ahead.
A. From January 2016 till early 2017, I produced reports from the data.
Q. And what was the purpose of those reports?

A. My boss asked me to do it.
Q. What was contained in the reports?
A. There's --
MR. SCARBER: I'm going to place an objection to relevance.
A. They're so old that I have no idea anymore.
BY MR. CROSS:
Q. So it wasn't even -- well, let's switch gears.
Do you believe it's important to determine the reason why someone is passing bright red blood from their rectum?
MR. SCARBER: Asked and answered, but go ahead.
A. Yes. It's important.
BY MR. CROSS:
Q. Why is it important?
A. Because there's a possibility that it could be pathologic or it's a possibility that it is benign or it could be a misread.
Q. What's pathologic mean?
A. Abnormal.
Q. And were you able to determine for sure, from the 407 requests that were submitted to you, that Mr. Lyles' rectal bleeding was caused by constipation?
A. That's not my position.
Q. Then what's your position?

A. My position is to make sure that somebody looks at that. That's the provider on site.
Q. But were you able to ascertain that that was the cause?
A. 20/20 vision retrospect, no, I could not ascertain that.
MR. CROSS: Okay. I don't have further questions.
MS. FOSTER: I don't have any questions for this witness.
MR. SCARBER: Okay. Let's take a quick break.
(At 1:00 to 1:08 p.m., recess taken.)
MR. SCARBER: We can go back on.
EXAMINATION
BY MR. SCARBER:
Q. Attorney Devlin Scarber appearing on behalf of the Corizon Defendants, including Dr. Papendick. Dr. Papendick, I have a few follow-up questions for you.
Were you utilizing your medical judgment when you were responding to the 407 requests concerning Andrew Lyles?
A. Absolutely.
Q. And was it your medical judgment, regarding your understanding of his particular conditions, that served as a basis for your determinations and decisions?
A. Yes.
Q. Now, when receiving a 407 request regarding an undiagnosed

GI bleed in the stool, what are the differentials that you are considering?
A. You have to consider infection, such as C. difficile -- that's capital C period d-i-f-f-i-c-i-l-e -- constipation, hemorrhoids, inflammatory bowel disease, irritable bowel disease, and colon cancer, or polyps that could be pre-colon cancer.
Q. Now, do these conditions that you describe have common symptoms, such as abdominal pain, change in bowel habits, bright red blood in the stool and diarrhea?
A. Yeah.
Q. And you talked about, in your experience, many inmates suffering from constipation in the prison.
Why? Why is that?
A. Well, they have a low fiber diet. I will tell you when I was working at Duane Waters, we had patients who had said they didn't want to drink water because they thought we had poisoned it. They don't have full access to movement, to get out and have exercise that would help them with the constipation.
Q. Do the inmates also complain of diarrhea and bloody stool with positive FOB tests and that's often caused by constipation?
A. Yes. It's called post-obstructive constipation or -- excuse me -- post-obstructive diarrhea, where the

constipation is obstructing the bowel, the bowel contents from coming down to the colon and, thus, the body liquifies the stool above the constipation, it goes around the constipation, and they actually get leaking a lot from that.

Q. What is -- it's a term -- what is loose stool overflow?

A. That's what I was just describing.

Q. Okay. Is that what you were describing?

A. Post-obstructive diarrhea.

Q. Have you experienced, in your position with Corizon and working in this capacity with inmates or reviewing requests concerning inmates, that relieving constipation will very often relieve an inmate's symptoms?

A. Absolutely. And I've actually had inmates who I got notes from the provider, that they wanted to thank me for taking care of their constipation issue so that they didn't have to have further testing and diagnostics.

Q. Mr. Cross was asking you about the January 6, 2017 407 request and ATP, and he asked you about medical necessity, the meaning of medical necessity not being demonstrated at this time and when symptoms demonstrate medical necessity, resubmit.

Do you believe that your decision at that point was reasonable?

A. Well, yes.

Q. And can you give me some reasons why you believe that and what your rationale is?

A. Well, there was never a time that the provider said that she didn't feel it was reasonable. The X-ray still needed to be redone. We don't need a GI consult to do any of those things.

Q. Was his hemoglobin and iron levels normal?

A. Yes.

Q. Does that play a role -- and I think you were discussing that with Mr. Cross -- in your decision?

A. Yes. Yes, it does.

Q. And why is that important for you?

A. Because significant, significant bleeding in the bowel, or anywhere, would cause anemia. And in this case there wasn't anemia, so he hadn't lost a great deal of blood, if he had lost any. Like I said, they could've misinterpreted what the red was.

Q. Had there been a significant amount of time between when the last physical was done and when you got the January 6th, 2017 report -- I'm sorry -- 407 request?

A. Oh, I think it was a month.

Q. Okay. The last X-ray it looks like demonstrating or referencing constipation was, I think, December 8th, 2016.

Could the Plaintiff have become constipated again by the time the January 6th 407 was submitted?

A. Absolutely.

Q. Over a month later?

A. Absolutely.

Q. Between January 17th and March 17th of 2017, the testimony in this case has been and the evidence in this case and records has been that -- or has demonstrated -- I'm sorry -- that Mr. Lyles' condition had improved, and I think that you had referenced that in your testimony with Mr. Cross?

A. Correct.

Q. Would that also be an indication to you that your decisions at the time that you made them, in your mind and in your medical judgment, were appropriate?

A. Yes. And he was, during that time as I recall, he was treated with antibiotics, which would go along with the C. diff diagnosis.

Q. So the final question to you, Dr. Papendick, do you believe, based upon the information, based upon the training and experience that you have and the information provided in the 407's, the information provided in the records, what we've found out concerning Mr. Lyles' condition, do you believe that with respect to all of those things and in consideration of all of those things, that your actions, regarding the 407 requests, were appropriate at the time that you issued your 407

responses?

A. Yes. They were appropriate.

MR. SCARBER: I don't have anything further.

MR. CROSS: All right. I have some cross, unless, Jennifer, you want to go?

RE-EXAMINATION

BY MR. CROSS:

Q. Okay. Dr. Papendick, your attorney asked you some questions about post-obstructive diarrhea; correct?

A. Yes.

Q. And you described a situation where there can be a obstruction and the body liquifies the stool to move the stool around the obstruction; correct?

A. Around the colon or -- excuse me. That's not quite correct.

Q. Okay.

A. It's around the constipated, it's around the constipated stool, not obstruction.

Q. So there is a constipated stool and then there is a liquid stool flowing around it?

A. Correct.

Q. Now, the constipated stool, is that something that could be visible on an X-ray?

A. Could be.

Q. Or it could not be visible on an X-ray?

A. Well, it may be read as normal if there's only one piece.
Q. Would that constipated stool affect the gaseous pattern of the viscera?
A. No.
Q. Would it affect the gaseous pattern in the colon?
A. Well, that is the viscera, but no.
Q. Okay. So how would one detect if this was a constipated stool or not if you can't detect it with an X-ray?
A. If they're having diarrhea, that makes no sense.
Q. So diarrhea would be evidence of the constipation?
A. Could be.
Q. Could be?
A. If he has post-obstructive diarrhea.
Q. So you just know there's bloody diarrhea; you don't know if it's postobstructive or not, but post-obstructive is one possibility?
A. First of all, I don't know that he's got bloody diarrhea. I know he's saying that he has bloody diarrhea and he had FOB positive studies that could be blood or may not be blood, and he has diarrhea, and at the time of having his diarrhea, he had X-rays demonstrating constipation.
Q. When was the X-ray done that demonstrated constipation?
A. I don't have that; you have it. There was one in November and I believe one in December.
Q. Do you know which one of those two demonstrated

constipation?
A. I believe both of them. It wasn't until January that it was read that there was no constipation.
Q. So blood in the stool could be caused by constipation; right?
A. Yes.
Q. Would that also cause weight loss?
A. If he's not eating correctly, yes.
Q. Would it cause left lower quadrant pain?
A. Yes.
Q. Are there other possible causes of bloody stool, weight loss and left lower quadrant pain besides constipation?
A. Yes.
MR. SCARBER: And I'll place an objection. Asked and answered.
BY MR. CROSS:
Q. And you were aware that it could have been one of those other causes; correct?
A. Certainly.
Q. Okay.
A. But the more common cause, the more common cause is constipation and we wanted to get that ruled out before we went further into this investigation, and he had to have his constipation cleared before we could do a colonoscopy.
MR. CROSS: All right. I don't have further

questions. Thank you.
MS. FOSTER: I still have no questions.
MR. SCARBER: I have nothing further. Thank you.
COURT REPORTER: Can I just get your orders?
MR. CROSS: I'd like an etrans.
MR. SCARBER: I'd like the same. Thank you.
MS. FOSTER: I'm good with a PDF mini. Thanks.
(At 1:23 p.m., Zoom deposition concluded.)

STATE OF MICHIGAN)
) SS
COUNTY OF KENT)

I certify that this transcript, consisting of 73 pages, is a complete, true and correct record of the testimony of said witness held in this case on Monday, August 23, 2021.
I also certify that prior to taking this deposition, the witness was duly sworn to tell the truth.

Date: 09-02-2021

Diane Murray

Diane Murray, CSR-4019, RPR
County of Kent, State of Michigan
My Commission expires: 10-12-2025

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